

# Wisconsin Department of Regulation & Licensing

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Madison, WI 53708-8935

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Madison, WI 53703  
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## NURSING HOME ADMINISTRATOR EXAMINING BOARD

### REQUEST TO APPLY FOR EXAMINATION

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.  
☐ Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth	Daytime Telephone Number
____ month ____ day ____ year	( ____ ) ____ - ____

Ethnic/gender status information is optional. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? \_\_\_\_ Yes \_\_\_\_ No (please indicate)  
If yes, provide your Wisconsin license/credential number. \_\_\_\_\_

### SECTION B:

1. Indicate the part(s) to be taken: ☐ Part I – NAB ☐ Part II – State Rules
2. Have you previously applied for or taken the examination(s) required for licensure in the State of Wisconsin?  
☐ Yes If Yes, when? \_\_\_\_\_ ☐ No

**Application Fee:** Make check payable to Department of Regulation and Licensing and attach check to application. The fees listed below are fees paid to the Department of Regulation and Licensing. Applicants are required to remit a separate payment to PES. See "Fee Payment" schedule in the instruction packet (Form #683).

- ☐ New Applicant (Parts I and II) – Fee \$121.00  
(\$53 credential fee; \$62 exam fee; \$6 CIB)
- ☐ Reciprocal Applicant (Part II) – Fee \$188.00  
(\$120 reciprocal fee; \$62 exam fee; \$6 CIB)  
Note: If you are currently licensed in another state, have passed the NAB and are applying by reciprocity, you will be required to take only Part II, State Law Examination.
- ☐ Retake Applicant
- ☐ State Law Exam only – Fee \$62.00
- ☐ NAB Exam only – Fee \$15.00
- ☐ Both Exams – Fee \$62.00

### For Receipting Use Only

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## 4. STATEMENT OF ARREST OR CONVICTION: (Attach additional sheets if necessary)

	<u>YES</u>	<u>NO</u>
A. Have you ever been convicted of a misdemeanor or a felony, or driving while intoxicated (DWI), in this or any other state, or are criminal charges currently pending against you? If yes, complete and attach Form #2222.	<input type="checkbox"/>	<input type="checkbox"/>
B. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
C. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation or revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
D. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
E. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
F. Do you currently hold, or have you in the past held, any credential (license) issued by the Department of Regulation and Licensing or any of the Boards? If yes, what type of credential? _____ And if in another name, what name? _____	<input type="checkbox"/>	<input type="checkbox"/>

Note: An arrest or conviction does not automatically disqualify an applicant. Consideration of the record by the board is subject to sec. 111.321, 111.322, and 111.335, Stats.

## 5. Indicate the provision applying under:

- ☐ Licensure by Reciprocity (secs. 456.08, Stats.; ch. NHA 4.03, Wis. Admin. Code). Reciprocity applicants may proceed to Item 6.
- ☐ Licensure by Examination (secs. 456.03, 456.04, 456.05, Stats.; ch. NHA 4, Wis. Admin. Code) and Education (ch. NHA 2.02(1)(c), Wis. Admin. Code). Indicate the educational program completed that satisfies the examination requirements (sec. 456.04, Stats.).
  - ☐ A. Regular Course of Study as defined in sec. NHA 1.02(7), Wis. Admin. Code. Graduation/Completion date: \_\_\_\_\_. Indicate below the course completed and submit an official transcript or certificate of completion.
    - ☐ Concordia University of Wisconsin, BA Health Care Administration (00019)
    - ☐ St. Joseph's College, Long Term Care Administration (00013)
    - ☐ Southern College of Seventh-Day Adventists, BS, LTC Admin (00021)
    - ☐ Southwest Texas State Univ., BS Health Professions LTC (00022)
    - ☐ Suny Institute of Tech, BS/BPS NHA Health Service Mgmt. (00023)
    - ☐ University of Minnesota LTC Program (00004)
    - ☐ UW-Eau Claire, NHA Baccalaureate Program (00002)
    - ☐ Upper Iowa University, Coordinated Off-Campus Degree Program (00014)
    - ☐ Viterbo College, Health Care Administration (00018)
    - ☐ Xavier University, Graduate Program in Hospital and Health Administration declaring 9 hours in gerontology (00017)
    - ☐ University of Scranton, Health Administration, Concentration in Long-Term Care Administration (00024)



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- ☐ B. **Specialized Course** as defined in sec. NHA 1.02(8), Wis. Admin. Code. Graduation/Completion date: \_\_\_\_\_. Indicate below the course completed and submit an official transcript or certificate of completion.

- ☐ Ohio State University, NHA Core of Knowledge Course (00008)
- ☐ St. Joseph's College, General Health Care Administration (00013). A separate course in long term care is required in addition to the completion of this course. Identify additional course: \_\_\_\_\_
- ☐ St. Mary's College, MA in Human & Health Services Admin. (00015)
- ☐ University of North Carolina, Long Term Care Admin LTCE #201 and LTCE #202 (00016)
- ☐ UW-Madison Extension, NHA Cassette Series (00010)
- ☐ UW-Eau Claire, HASA Certificate (00025)

- ☐ C. **Program of Study** as defined in sec. NHA 1.02(6), Wis. Admin. Code.

Indicate below the program of study completed and submit an official transcript or certificate of completion. (88888)

- ☐ Ottawa University-Milwaukee, LTC Program, Graduation/Completion Date: \_\_\_\_\_
- ☐ If program of study is not listed, indicate below the program of study completed and submit an official transcript along with the course description.

1. Laws governing the operation of licensed nursing homes:

Title of Course \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_

2. Elements of proper and effective administration of licensed nursing homes:

Title of Course \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_

3. Protection of the interests, safety and well-being of residents:

Title of Course \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_

4. Psychological, physical, medical and social needs of residents:

Title of Course \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_

## 6. **THIS SECTION IS TO BE COMPLETED BY RECIPROCAL APPLICANTS ONLY:**

- a. Provide the name of each state in which you hold a credential, the credential number, date granted, and the expiration date. Please indicate if the credential was obtained through examination or reciprocity. For each state listed, submit an original Verification of Licensure (Form #419) completed by the licensing authority. **A photocopy of your license is not acceptable.**

<u>Name of State</u>	<u>Credential Number</u>	<u>Date Granted</u>	<u>Expiration Date</u>	<u>Examination or Reciprocity</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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- b. Please provide below information that you have obtained a bachelor's degree in any field from an accredited college or university. You must submit an official transcript as verification of completion.

Courses Completed or Degree Obtained: \_\_\_\_\_

Graduation or Completion Date: \_\_\_\_\_

Name & Address of College or University: \_\_\_\_\_

- c. If you have not received a bachelor's degree, submit a current certification as a nursing home administrator granted by the American College of Health Care Administrators.
- d. Indicate whether you have been engaged in practice as a nursing home administrator for no fewer than 2,000 hours in any consecutive 3-year period within the 5-year period immediately preceding this application (ch. NHA 4.03(2), Wis. Admin. Code). ☐ Yes ☐ No

If yes, please complete the Reciprocity Experience Record (Form #2470).

## 7. **AFFIDAVIT OF APPLICANT**

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential or other disciplinary action. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Nursing Home Administrator Examining Board or the Department of Regulation and Licensing will be cause for disciplinary action.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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**SOCIAL SECURITY NUMBER.** Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.<sup>1</sup> A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

\_\_\_\_\_  
First Name                                      Middle Initial                                      Last Name

\_\_\_\_\_  
Profession

Date of Birth      \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
                                 month                                      day                                      year

-  -

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,<sup>2</sup> to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,<sup>3</sup> and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.<sup>4</sup>

<sup>1</sup> Section 440.03 (11m), Wis. Stats.

<sup>2</sup> Sections 49.22, and 440.13, Wis. Stats.

<sup>3</sup> Section 440.12, Wis. Stats.

<sup>4</sup> Health Insurance Portability and Accountability Act (HIPAA) of 1996